



# THE INDIVIDUALIZED SUPPORT PLAN

State Form ( )

\*THIS STATE AGENCY IS REQUIRING DISCLOSURE OF YOUR SOCIAL SECURITY NUMBER PER IC 4-1-8-1. THE INFORMATION OBTAINED ON THIS FORM IS CONFIDENTIAL UNDER STATE AND FEDERAL REGULATIONS. THIS INFORMATION WILL NOT BE RELEASED EXCEPT AS PERMITTED OR REQUIRED BY LAW OR WITH THE CONSENT OF THE APPLICANT.

Name of Individual NORM SAMPLE Social Security # 333-22-0000

☐ Female ☐ Male

Name of Facilitator CASE MANAGER Date of ISP 10/9/02

Medical Insurance MEDICAID

☐ Initial ☒ Revised

## Individual's Personal and Demographic Information

Last Name SAMPLE First Name NORM MI W  
Address 45 EAST STREET  
City CHESTERTON State IN Zip 38765  
DOB 3-02-80 RID# 1000109383487 Legal Status Individual With Legal Guardian  
Current Living Arrangement: IN APARTMENT WITH ONE OTHER INDIVIDUAL  
The Individual is currently ☐ In School ☐ Employed ☒ Other (Specify ABC WORKSHOP)

## Individual's Diagnosis

PRIMARY MR SECONDARY \_\_\_\_\_

## Individual's Emergency Contacts

Name JOE GUARDIAN Phone # (217) 345-0000 Relationship Parent  
Address 1987 WEST STREET CHESTERTON IN. 47654  
Alternate contact method WORK - (217) 948-8764 JOEG@HOTMAIL.ORG

Name ROGER TEAM LEADER Phone # (217) 345-9843 Relationship Other  
Address 48376 NORTH STREET AT ABC WORKSHOP  
Alternate contact method PAGER - 800-984-7265 PIN 48765

Name \_\_\_\_\_ Phone # \_\_\_\_\_ Relationship \_\_\_\_\_  
Address \_\_\_\_\_  
Alternate contact method \_\_\_\_\_

Name \_\_\_\_\_ Phone # \_\_\_\_\_ Relationship \_\_\_\_\_  
Address \_\_\_\_\_  
Alternate contact method \_\_\_\_\_

❖ Attach Person Centered Planning Profile Information



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Name of Individual NORMA SAMPLE  
Date of Support Plan 10/9/02

## Outcome towards which this Individualized Support Plan will work

**Desired Outcome** HAVING A JOB. NORM ENJOYS WORKING IN THE COMMUNITY AND MAKING MONEY

**Current Status** CURRENTLY WORKS AT ABC WORKSHOP. DOES NOT LIKE DOWNTIME. VR CASE IS CLOSED. SOME QUESTIONS ABOUT WORK RESTRICTIONS DUE TO LEG AND VEIN PROBLEMS.

**Past Experiences** NORM SUCCESSFULLY WORKED AT A LOCAL FACTORY IN THE PAST. VR CASE WAS CLOSED. WAS LAID OFF IN THE WINTER. MAY NOT HAVE BEEN THE BEST JOB MATCH. NORM STATES THAT HE WOULD LIKE TO DO JANITORIAL WORK/CLEANING. NORM MIGHT BENEFIT FROM SOME JOB EXPLORATION.

<u>Proposed Strategy/Activity</u>	<u>Responsible Party</u>	<u>Time Frame</u>	<u>Progress Note</u>
1. MAKE REFERRAL TO VR FOR EITHER SUPPORTED EMPLOYMENT OR COMM. EVALUATION	SUE COORDINATOR JOE GUARDIAN	10-31-02	
2. GET APPOINTMENT WITH CARDIOVASCULAR PHYSICIAN TO DISCUSS ANY WORK RESTRICTIONS	ROGER - TEAM LEADER	10-31-02	
3. PROVIDE OPPORTUNITIES FOR JOB EXPLORATION.	VR	12-31-02	
4. OBTAIN JOB WITH NEEDED SUPPORTS FOR TRAINING AND FOLLOW-ALONG	VR	3-31-03	
5. CONTINUE AT ABC WORKSHOP UNTIL JOB IS SECURED	ABC WORKSHOP	ONGOING	



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Name of Individual NORM SAMPLE

Date of Support Plan 10-9-02

## Outcome towards which this Individualized Support Plan will work

**Desired Outcome** STAYING HEALTHY AND ACTIVE

**Current Status** LEGS ARE BETTER, BUT ULCERS MAY BE STARTING AGAIN. HIS PHYSICIAN HAS BEEN UNWILLING TO REFER TO A CARDIOVASCULAR SPECIALIST. HAS HEARING AID BUT DOES NOT WEAR.

**Past Experiences** NORM HAS HAD SIGNIFICANT CONCERNS WITH HIS LEG VEINS AND ULCERS ON HIS LEGS. THEY HAD HEALED, BUT CURRENTLY ARE STARTING UP AGAIN. NORM GAINED SOME WEIGHT WHEN FIRST MOVING INTO APARTMENT, BUT HAS NOW LEVELED OFF. NORM STAYS ACTIVE, INCLUDING SPECIAL OLYMPICS AND WALKING AFTER DINNER.

<u>Proposed Strategy/Activity</u>	<u>Responsible Party</u>	<u>Time Frame</u>	<u>Progress Note</u>
1. GET APPOINTMENT WITH CARDIOVASCULAR PHYSICIAN (EITHER THROUGH PRIMARY PHYSICIAN OR PODIATRIST)	ROGER - TEAM LEADER	10-31-02	
2. GET APPOINTMENT WITH DR. EAR TO CHECK EARS	ROGER - TEAM LEADER	10-31-02	
3. CONTINUE WITH SPORTS AND WALKING AFTER DINNER. WATCH PORTIONS AT MEALS	ROGER - TEAM LEADER	ONGOING	
4. CONTINUE WITH REGULAR PHYSICIAN, PODIATRIST, DENTAL AND VISION APPOINTMENTS	ROGER - TEAM LEADER	ONGOING	



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## Outcome towards which this Individualized Support Plan will work

**Desired Outcome** INCREASE INVOLVEMENT IN COMMUNITY BY BECOMING A MEMBER OF A CHURCH AND REGULARLY ATTENDING AND OBTAINING A VOLUNTEER JOB RELATED TO PETS

**Current Status** NORMS ATTENDS CHURCH OCCASSIONALLY WITH DIFFERENT STAFF MEMBERS, BUT DOES NOT BELONG TO ANY PARTICULAR CHURCH. HE DOES NOT VOLUNTEER. HE ENJOYS PETS AND LIKES TO HELP OTHERS.

**Past Experiences** NORM ENJOYS ATTENDING CHURCH. HE PARTICULARLY LIKED ROSEFLOWER CATHOLIC CHURCH (AND THIS IS CLOSE TO HIM). IN THE PAST, HE ENJOYED PASSING OUT CHURCH PROGRAMS AT A DIFFERENT CHURCH HE ATTENDED.

<u>Proposed Strategy/Activity</u>	<u>Responsible Party</u>	<u>Time Frame</u>	<u>Progress Note</u>
1. CONTACT DEACON AT ROSEFLOWER FOR GUIDELINES ABOUT MEMBERSHIP AND DISCUSS POSSIBILITIES FOR SUPPORT AND TRANSPORTATION	ROGER - TEAM LEADER CINDY FRIENDLY	10-31-02	
2. BEGIN ATTENDING ROSEFLOWER REGULARLY, BECOME A MEMBER	ROGER - TEAM LEADER CINDY FRIENDLY	10-31-02	
3. CONTACT POSSIBLE PET/ANIMAL PLACES FOR VOLUNTEER POSSIBILITIES	JOE G CONTACT PET REFUGE ROGER - TEAM LEADER CONTACT ZOO	11-15-02	
4. SECURE A REGULAR VOLUNTEER ACTIVITY IN PLACE NORM ENJOYS	ROGER - TEAMLEADER	1-1-03	
5. CONTINUE BUS TRAINING	ABC WORKSHOP STAFF	10/9/03	



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## Statement of Agreement

I have been involved in the development of my Individualized Support Plan and I agree with this Plan.  
I know I can appeal to the DDARS if I disagree with how this plan is put into action.

Signed \_\_\_\_\_ Date \_\_\_\_\_  
*Individual for whom this plan was written* *date signed*

Signed \_\_\_\_\_ Date \_\_\_\_\_  
*Guardian of Individual, if applicable* *date signed*

## Individualized Support Plan Participants

Participant	Relationship	Date plan was sent	Sent via
Norm Sample	Self	10/9/02	<input type="checkbox"/> E-mail <input type="checkbox"/> Postal Mail <input type="checkbox"/> Telephone <input checked="" type="checkbox"/> In Person <input type="checkbox"/> Fax
Roger - Team Leader	Team Leader	10/9/02	<input checked="" type="checkbox"/> E-mail <input type="checkbox"/> Postal Mail <input type="checkbox"/> Telephone <input type="checkbox"/> In Person <input type="checkbox"/> Fax
Joe Guardian	Guardian	10/9/02	<input type="checkbox"/> E-mail <input checked="" type="checkbox"/> Postal Mail <input type="checkbox"/> Telephone <input type="checkbox"/> In Person <input type="checkbox"/> Fax
Cindy Friendly	Residential Provider Staff	10/9/02	<input type="checkbox"/> E-mail <input checked="" type="checkbox"/> Postal Mail <input type="checkbox"/> Telephone <input type="checkbox"/> In Person <input type="checkbox"/> Fax
Case Manager	Case Manager	10/9/02	<input type="checkbox"/> E-mail <input checked="" type="checkbox"/> Postal Mail <input type="checkbox"/> Telephone <input type="checkbox"/> In Person <input type="checkbox"/> Fax
			<input type="checkbox"/> E-mail <input type="checkbox"/> Postal Mail <input type="checkbox"/> Telephone <input type="checkbox"/> In Person <input type="checkbox"/> Fax
			<input type="checkbox"/> E-mail <input type="checkbox"/> Postal Mail <input type="checkbox"/> Telephone <input type="checkbox"/> In Person <input type="checkbox"/> Fax
			<input type="checkbox"/> E-mail <input type="checkbox"/> Postal Mail <input type="checkbox"/> Telephone <input type="checkbox"/> In Person <input type="checkbox"/> Fax
			<input type="checkbox"/> E-mail <input type="checkbox"/> Postal Mail <input type="checkbox"/> Telephone <input type="checkbox"/> In Person <input type="checkbox"/> Fax



# THE INDIVIDUALIZED SUPPORT PLAN

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## Meeting Issues and Requirements

*Comments boxes will expand to accept text*

**The Individualized Support Plan team shall check any of the following Health and Behavioral Issues that may concern the individual and explain how they are met or addressed by this plan.**

	Comments
<input checked="" type="checkbox"/> If a Provider is needed to provide health and behavioral support (Name the provider responsible)	RESIDENTIAL PROVIDER IS RESPONSIBLE
<input checked="" type="checkbox"/> Seizures, or History of Seizures	None
<input checked="" type="checkbox"/> Allergies, or History of Allergies	None
<input checked="" type="checkbox"/> Uses or Requires Dentures	None
<input checked="" type="checkbox"/> Chewing Difficulties	None
<input checked="" type="checkbox"/> Swallowing Difficulties	None
<input checked="" type="checkbox"/> Dining Difficulties	None
<input checked="" type="checkbox"/> Vision Difficulties	None
<input checked="" type="checkbox"/> Hearing Difficulties	Has hearing aids but does not wear. Appointment being scheduled with ear doctor.
<input checked="" type="checkbox"/> Speaking Difficulties / Mode of Communication	None
<input checked="" type="checkbox"/> Behavior Issues	None
<input checked="" type="checkbox"/> Issues discovered through review of Incident Reports	There was a report from residential provider about losing electric in a storm and the need to take Norm to the ER when he fell while playing basketball at Special Olympics. He had stitches to his knee and these were removed and no problems encountered.
<input checked="" type="checkbox"/> Medication/Self Medication Issues	Meds now locked up – strategy in place in ISP to work on self-medication issues.
<input checked="" type="checkbox"/> Lab Testing	None at this time
<input checked="" type="checkbox"/> Other chronic conditions or healthcare issues	Setting up an appointment for him to see cardiovascular doctor for legs - vein and ulcer problems.
<input checked="" type="checkbox"/> Regular family physician	Gets annual exam
<input checked="" type="checkbox"/> Dentist	annual exam
<input checked="" type="checkbox"/> Specialist (seizures, mental health issues, etc.)	See other chronic above



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## Meeting Issues and Requirements

*Comments boxes will expand to accept text*

### The Individualized Support Plan Team must show which of the following Safety and Environmental Requirements have been met by this Plan, and how.

	Comments
<input checked="" type="checkbox"/> If a Provider is needed to provide environmental and living arrangement support (Name provider responsible)	Residential provider
<input checked="" type="checkbox"/> Carbon Monoxide Detectors	Support team determined that this is not needed
<input checked="" type="checkbox"/> Smoke Detectors	Are in the home and working
<input checked="" type="checkbox"/> Emergency Phone Numbers	These are posted by the phone
<input checked="" type="checkbox"/> Emergency Evacuation Routes and Plan	Residential staff review monthly with Norm and his roommate what to do in case of an emergency. Norm is able to state what he is to do.
<input checked="" type="checkbox"/> Fire Extinguishers	One in the kitchen and checked 3/18/02
<input checked="" type="checkbox"/> Insurance	Renters insurance is covered By Joe Guardian
<input checked="" type="checkbox"/> Anti-Scalding Devices	Norm is able to mix water, as is his roommate. Has been determined that no anti-scald is needed and water temperature is set at 110 degrees.
<input checked="" type="checkbox"/> Devices and Home Modifications	None needed
<input checked="" type="checkbox"/> Personal Emergency Response System	None needed
<input checked="" type="checkbox"/> Current Photograph in Personal File	We do not have a current photo and Support Team does not recommend that one is needed.
<input checked="" type="checkbox"/> Transportation	ABC workshop helps Norm with bus training.
<input checked="" type="checkbox"/> Individual's Property/Financial Resources (Name provider)	Residential provider



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**Meeting Issues and Requirements**

*Comments boxes will expand to accept text*

**The Individualized Support Plan Team must show which of the following Provider Requirements have been met by this Plan, and how.**

	Comments
<input checked="" type="checkbox"/> 1 <sup>st</sup> Case Manager contact after ISP implementation	30 DAYS
<input checked="" type="checkbox"/> Frequency of Case Manager monitoring visits	90 DAYS
<input checked="" type="checkbox"/> Maintaining individual's personal file (Name provider)	RESIDENTIAL PROVIDER
<input checked="" type="checkbox"/> Analyzing and updating of records (Frequency)	SUPPORT TEAM WILL REVIEW EVERY 90 DAYS
<input checked="" type="checkbox"/> Frequency at which Individual is informed of <div><input checked="" type="checkbox"/> Medical Condition    <input checked="" type="checkbox"/> Developmental Status <input checked="" type="checkbox"/> Behavior Status      <input checked="" type="checkbox"/> Risk of Treatment</div>	ANNUALLY



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## Optional Attachment: Resources

### This individual is currently receiving funding support from the following sources:

☐ DFC ☐ BDDS ☐ DOE Wrap-Around ☐ Voc. Rehab. ☐ CHOICE ☒ Medicaid Waiver

If Individual is receiving  
Waiver funds, which Waiver? Dd

☒ SSI ☐ SSDI ☒ Medicaid ☐ Medicare ☐ Trust Fund ☒ Employment Earnings

Other / Comments:

### The team and the individual discussed funding support from the following sources:

☐ DFC ☐ BDDS ☐ DOE Wrap-Around ☒ Voc. Rehab. ☐ CHOICE ☐ All Medicaid Waivers

☐ SSI ☐ SSDI ☐ Medicaid ☐ Medicare ☐ Trust Fund ☐ Employment Earnings

Other / Comments:

### This individual does not desire funding support from the following sources:

☒ DFC ☐ BDDS ☒ DOE Wrap-Around ☐ Voc. Rehab. ☒ CHOICE ☐ Medicaid Waiver

Which Waiver(s)?

☐ SSI ☒ SSDI ☐ Medicaid ☒ Medicare ☒ Trust Fund ☐ Employment Earnings

Other / Comments:

### This individual has applied for funding support from the following sources:

☐ DFC ☐ BDDS ☐ DOE Wrap-Around ☐ Voc. Rehab. ☐ CHOICE ☐ Medicaid Waiver

Which Waiver(s)?

☐ SSI ☐ SSDI ☐ Medicaid ☐ Medicare ☐ Trust Fund ☐ Employment Earnings

Other / Comments:

### This individual is currently on a waiting list for the following supports:

☐ DFC ☐ BDDS ☐ DOE Wrap-Around ☐ Voc. Rehab. ☐ CHOICE ☐ Medicaid Waiver

Which Waiver(s)?

☐ SSI ☐ SSDI ☐ Medicaid ☐ Medicare ☐ Trust Fund ☐ Employment Earnings

Other / Comments: